

Aetna**FAMILY LEAVE AND FAMILY MEDICAL LEAVE REQUEST**

Side 1

RECEIVED
SEP 10 2001REJECTED
SEP 11 2001
DATA MARK**REFER TO THE INSTRUCTIONS BEFORE COMPLETING THIS FORM**

| | | | |
|---|--|---|------------------------|
| 1. Employee's Name (last, first, middle initial) Baily, Lisa M | | 2. Aetna ID 718168 | 3. Mail Location Code |
| 4. Home Address (Number, Street, City, State, Zip Code) 4098 Locust Dr. Northampton PA 18067 | | | |
| 5. Work Telephone Number () | | 6. Adjusted Date of Hire 3-96 | |
| 7. Manager's Name Patricia Maroun | | 8. Manager's Telephone Number (610) 391-4650 | 9. Manager's Mail Code |
| 10. Check scheduled work days: <input type="checkbox"/> S <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> W <input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> F <input type="checkbox"/> S | | | |
| 11. Type of Leave Requested <input type="checkbox"/> Family Leave - for birth/adoption/foster care placement of a child and/or to care for the child within 12 months of birth/adoption/placement. <input checked="" type="checkbox"/> Family Medical Leave - for care of an eligible family member with a serious health condition. Eligible family members include a spouse, domestic partner, child, child of a domestic partner, parent, parent-in-law, parent of a domestic partner, or other household member. <input checked="" type="checkbox"/> Discretionary Aetna Family Leave (more than 16 weeks; up to 6 months total leave). <input type="checkbox"/> Other (specify, e.g., for Oregon employees, family medical leave to care for a child with a non-serious health condition): | | | |
| Name of Family Member: _____ | | Relationship to Employee: _____ | |
| 12. If requesting Family Leave or Family Medical Leave on an intermittent or reduced leave schedule basis, specify the days and/or hours for which you are requesting intermittent leave or a reduced schedule. | | | |
| 13. Length of Leave (e.g., 8 weeks) 4 weeks | | 14. Dates of Absence FROM 8/2/01 THROUGH 8/31/01 | |
| 15. I understand that if it is determined that I am not eligible for Family Leave or Family Medical Leave under Aetna's Family and Medical Leave policy or any applicable federal/state/local leave laws or other Aetna policy, my absences may be counted for attendance disciplinary purposes. I certify that the information contained in this Request is true and that I need leave for the purpose(s) stated in this Request. I authorize Aetna's Occupational Health Services Unit to contact my family member's health care provider in the event the medical information submitted to Aetna by my family member's provider in support of my request for Family Medical Leave needs clarification or authentication. | | | |
| 16. Employee's Signature Lisa Baily | | 17. Date Employee Requested Family Leave/Family Medical Leave 8-31-01 | |
| 18. Manager's Signature | | 19. Date Employee Requested Family Leave/Family Medical Leave | |

Manager: Give a completed and signed copy of this form to the employee.
Place a copy in the employee's personnel file.



FAMIL. LEAVE AND FAMILY MEDICAL LEAVE ACKNOWLEDGEMENT

Side 2

(To be completed by the manager to acknowledge a request for Family Leave or Family Medical Leave)

REFER TO THE INSTRUCTIONS BEFORE COMPLETING THIS FORM

| | | |
|-----------------------|------------------------|-------|
| To: (Employee's Name) | From: (Manager's Name) | Date: |
|-----------------------|------------------------|-------|

Part I. Check one of the following:

- ☐ I have received your request for Family Leave protection for the period(s) specified in items 12., 13. and 14. on Side 1 of this form and reviewed your leave eligibility and allotment under the federal Family and Medical Leave Act, applicable state and local leave laws, and Aetna's Family and Medical Leave (FML) policy.
- ☐ I have received your request for Family Medical Leave protection for the period(s) specified in items 12., 13. and 14. on Side 1 of this form and reviewed your leave eligibility and allotment under the federal Family and Medical Leave Act, applicable state and local leave laws, and Aetna's Family and Medical Leave (FML) policy.

Part II. Check appropriate responses below and give a copy of this acknowledgment to the employee.

On the basis of my review:

1. ☐ You are not eligible for leave under Aetna's FML policy because:
 - a. ☐ You do not meet the eligibility requirements for leave (1,000 of work in the 12 months before leave begins and 12 months of service). I anticipate that you will meet these eligibility requirements on ____/____/____ (date).
 - b. ☐ You previously exhausted your FML allotment of 16 weeks. I anticipate that you will be eligible for leave again on ____/____/____ (date).
 - c. ☐ Other (specify, e.g., failure to request leave within two business days of return to work, lack of medical certification, etc.): _____
2. ☐ You are not eligible for leave under Aetna's mandatory policy but you are eligible for leave under state/local law. Your _____ hours/days/weeks of leave will be counted as both state/local statutory leave and Aetna FML leave.
3.
 - a. ☐ Your absence has been approved for protected Family Leave.
 - b. ☐ Your absence has been approved for protected Family Medical Leave.
4. Terms of the leave:
 - a. ☐ The following time will be counted against your leave allotment under Aetna's FML policy and/or applicable federal, state and local law:
List days/weeks of certified Family Leave/Family Medical Leave: _____
 - b. ☐ You are eligible for leave on an intermittent basis, as follows (specify frequency/duration of intermittent leave). This time will be counted against your leave allotment under Aetna's FML policy and/or applicable federal, state and local law:
List hours/days/weeks of certified intermittent leave: _____
 - c. ☐ You are eligible for a reduced leave schedule, as follows (specify the reduced leave schedule and the period for which it is approved). This time will be counted against your leave allotment under Aetna's FML policy and/or applicable federal, state and local law:
List hours/days/weeks of approved reduced leave schedule: _____

Any additional time that is approved for Family Leave or Family Medical Leave protection also will be counted as statutory and Aetna FML leave until you have used 16 weeks of leave in a rolling 12-month period. For Family Medical Leave only: You may be required to provide additional medical certification from your eligible family member's health care provider to support your need for additional leave. Failure to submit additional medical information within 15 calendar days of a request for this information or to provide adequate medical information may result in treatment of your leave as not legally protected. Be sure to review the department's attendance policy to determine when unscheduled, unprotected absences will result in disciplinary action.

Manager's Signature _____

Manager: Give a completed and signed copy of this form to the employee.
Place a copy in the employee's personnel file.

8-31-01

As requested by my lawyer here is
my request for family and medical
leave as I was not told that I was
allowed to have this done until later
by my lawyer. If you need an information
let me know.

David Bailey

William and Lisa Bally
4098 Locust Dr.
Northampton, PA. 18067

AETNA
3541 WILCHESTER RD
ALEXANDRIA, VA 22304

18104+3311

18104+3311

